VHCA
Vermont Health Care Association

Representing Quality Health Care Homes

April 27, 2012

Commissioner Mark Larson
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Re: Comments to Draft Demonstration Grant to Integrate Care for Dual Eligible Individuals

Dear Commissioner Larson:

Thank you for the opportunity to provide comment on the above referenced draft proposal. VHCA has been an active participant in the stakeholder workgroup for many months. While there may be opportunities to improve care coordination, and opportunities to waive a variety of Medicare rules with the goal of improving access to quality care and reducing costs[1], a number of lingering questions remain outstanding from our members' perspective. VHCA eagerly awaits an opportunity to review the long-awaited financing model for the demonstration.

Administrative Burden and Cost

One of the goals of the demonstration waiver is administrative simplification and reduction of administrative costs. However, VHCA remains unconvinced that this will be the outcome from a provider perspective. Currently there are two sets of rules- one set for Medicaid only and one set for Medicare only. Under this proposal, providers will be following different rules under three programs- Medicaid only, Duals, and Medicare only. This will increase administrative burden and cost to providers, and add to confusion. This is an issue that cannot be ignored.

The Need for Presumptive Eligibility for Duals

VHCA has expressed concern on a number of occasions about the potential risk to providers of having no payment source, but it is not evident from the draft that this concern is recognized. While the current population of 22,000 duals may be "known" to the state, more will enter duals status on a rolling basis due to age and change in financial status. It is possible a patient may enter the nursing home, be eligible for

[1] VHCA has on several occasions recommended the following with regard to Medicare rules for the duals population: elimination of the three day qualifying hospital stay and/or counting of observation days toward the three day stay; allowing initial visits of nursing facility patients to be performed by nurse practitioners and physician assistants; limitations on the use of hospital swing beds and out-of-state nursing facility placements; and funding of tele-health services in all counties of the state.

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Medicare and have Medicaid status pending. Provider experience with Medicaid instructs that it can take months, and sometimes longer, for a financial eligibility determination on Medicaid. All the while, treatment is being provided under the assumption and hope that Medicaid will be granted based upon the best available financial information at the time of admission.

The problem will come 6 months after admission, after services have been provided, and the patient is denied Medicaid- therefore is not dually eligible. This occurs now with the Medicaid only population- leaving the provider with no source of payment. This issue will now be that much more complicated. If the nursing facility did not follow the Medicare rules for the Medicare only population because the resident was thought to qualify as a dual, and it takes Medicaid months to deny financial eligibility- 90 days of rehab or other services will not be covered by Medicare, and the state won't reimburse the facility if the patient is not a dual. The effect is that unless Medicaid eligibility is certain at the time of admission, a facility would need to follow all of the standard Medicare rules (i.e. 3 day stay) or risk not having a payment source. The bottom line is that this creates a complicated system. The default solution will be to treat potential duals as Medicare only from a facility perspective. The result is that any added flexibility to be gained from flexibility in the rules will not be realized. There should be presumptive eligibility under certain circumstances so that the state covers the reimbursement in these situations even if Medicaid is denied months later.

Medicare Part D

VHCA is also concerned with the move to incorporate Medicare Part D plans into the statewide drug formulary currently available to Medicaid beneficiaries. Currently, the state does not pay for extended release drugs in nursing facilities under Medicaid. Dually eligible patients would presumably also be prohibited from obtaining these drugs under the demonstration. VHCA would like the state to consider expanding the formulary to include extended release drugs for both Medicaid beneficiaries and those who are dually eligible. It is the experience of our members that when appropriate, utilization of extended release drugs improves health outcomes and lowers overall healthcare costs.

Provider Reimbursement

In addition, the draft demonstration proposal provides little information regarding provider payment methodologies. While the state may be inclined to move toward a blended payment model for the dual eligible population, several points must be considered. First, administratively this creates a third government payment model for nursing facilities, thereby increasing provider cost and administrative burden. Second, Medicaid rates do not currently reimburse nursing facilities for therapies, so any blended model would need to account for this care. Any new payment model must also account for the current cost shift of nursing facility Medicaid losses on to Medicare. Any suggested modifications to nursing facility rate setting must undergo a thorough review and discussion with the industry to achieve the best results.

In general, any modifications to reimbursement systems for nursing facilities and ERCs must appropriately reflect the needs of memory impaired individuals and those with mental health/behavioral health challenges. Care for these residents is currently underfunded.

Reimbursement methodologies should also provide positive incentives to improve quality outcomes, such as reduced hospitalizations. VHCA was pleased to see this component specified in the draft proposal.

Impact of Reduced Utilization on Providers

Throughout the draft proposal, there is emphasis on continued reduced utilization of nursing facilities. The state must work with nursing facilities to develop alternative strategies to ensure the continued availability and viability of high quality nursing facility services. Given the state's demographics, the expertise and resources available in our nursing facilities must be put to their highest use.

Enhanced Care Coordinators & Integrated Service Providers

VHCA believes the state should keep an open mind regarding entities that might act as Enhanced Care Coordinators and Integrated Service Providers. Long-term care facilities may be appropriate enhanced care coordinators or integrated service providers for the population they serve. The state should ensure that the process for selecting such entities is flexible enough to ensure that these providers can respond to the needs of the population they serve in this manner if they so desire.

Opportunities for "Re-Investment"

ACCS and ERC services in our residential care homes and assisted living residences are currently critically underfunded, resulting in access concerns. These services are valuable components of our long-term care system, and reimbursement must be adequate to ensure the continued viability of providers. It is VHCA's hope that the state will be able to inject much needed resources into this sector.

Capital investment in long-term care facilities for HIT is needed. While VHCA has begun to make gains on identifying the needs in this area with assistance from DVHA, facilities do not have the resources to make the necessary investments.

As nursing facilities continue the culture change journey, investment in private rooms for Medicaid beneficiaries and duals is needed. Reimbursement should compensate facilities for private rooms.

Sincerely,

Laura Q. Pelosi
Executive Director